

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011914	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/15/2013
NAME OF PROVIDER OR SUPPLIER CROWN POINTE SENIOR LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1034 CROWN POINTE BLVD GREENSBURG, IN 47240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: March 14 and 15, 2013</p> <p>Facility number: 011914 Provider number: 011914 AIM number: N/A</p> <p>Survey team: Angel Tomlinson RN TC Leslie Parrett RN</p> <p>Census bed type: Residential: 29 Total: 29</p> <p>Census payor type: Other: 29 Total: 29</p> <p>Sample: 7</p> <p>Crown Pointe Senior Living Community was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey.</p> <p>Quality review 3/19/13 by Suzanne Williams, RN</p>	R 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

32K611

If continuation sheet 1 of 1